Back on Track chiropractic

Our mission is to educate and adjust as many people as possible toward optimal health using natural chiropractic care.

CONFIDENTIAL PATIENT INFORMATION:

Today's Date: _____

Name: _____

Date of Birth: _____

Address: _____ **City:** _____

State: _____ **Zip:** _____ **Email:**_____

Home Phone: _____**Work Phone:** _____ **Cell Phone:** _____

Social Security #: _____ **Age:** _____ ☐ **Male** ☐ **Female**

Marital Status: ☐ **Married** ☐**Single** ☐**Divorced** ☐**Separated** ☐**Other** _____

Name of Spouse/Nearest Relative: _____**Phone:** _____

Your Occupation_____ **Your Employer:** _____

Referred to this Office by: ☐**Friend/Family Member - Name?** _____

☐**Yellow Pages** ☐ **Mail** ☐**Clinic Location** ☐**Other**_____

Payment for Services will be: ☐**Cash** ☐**Check** ☐**Automobile Insurance** ☐**Worker's Compensation** ☐**Health Insurance**

Name of Insurance Co.: _____

Insured's Employer: _____

Insured's Social Security #: _____

Are you covered by more than one insurance company? ☐**Yes** ☐**No**

If Yes, Name of other insurance company _____

ACCIDENT HISTORY:

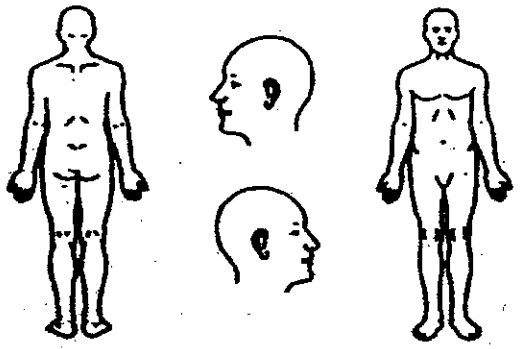
☐**Job** ☐**Auto** ☐**Other 1**_____ **Date:**_____

☐**Job** ☐**Auto** ☐**Other 2.**_____ **Date:**_____

☐**Job** ☐**Auto** ☐**Other 3.**_____ **Date:**_____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

Circle areas of complaint below



PLEASE RATE YOUR SYMPTOMS (1-10, 1 being the least serious)

	DESCRIPTION	RATING
1	_____	_____
2	_____	_____
3	_____	_____
4	_____	_____

SYMPTOMS ARE WORSE IN ☐**MORNING** ☐**AFTERNOON** ☐**NIGHT**

SYMPTOMS DEVELOPED FROM: ☐**JOB RELATED INJURY** ☐**AUTO ACCIDENT** ☐**OTHER ACCIDENT** ☐**ILLNESS** ☐**UNKNOWN CAUSE** ☐**GRADUAL ONSET**

DATE OCCURRED: _____

SYMPTOMS HAVE LASTED____**HOUR(S)** ___**DAY(S)** ___**WEEK(S)** ___**MONTH(S)**__**YEAR(S)**

SYMPTOMS/COMPLAINTS: ☐**COME & GO** ☐**ARE CONSTANT**

HAVE YOU EVER HAD THIS BEFORE: ☐**NO** ☐**YES WHEN?** _____

ARE YOU PREGNANT ☐**NO** ☐**YES** **DATE OF LAST MENSTRUAL PERIOD**_____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION: ☐BENDING ☐REACHING ☐STRAINING AT STOOL ☐COUGHING ☐SITTING ☐TURNING HEAD ☐LIFTING ☐SNEEZING ☐WALKING ☐LYING DOWN ☐STANDING

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION: ☐BENDING ☐SITTING ☐LIFTING ☐STANDING ☐LYING DOWN ☐TURNING HEAD ☐REACHING ☐WALKING

PLEASE CHECK ANY ADDITIONAL SYMPTOMS YOU MAY BE EXPERIENCING: ☐blurred vision ☐buzzing in ears ☐cold feet ☐cold hands ☐cold sweats ☐concentration loss/confusion ☐constipation ☐depression/weeping spells ☐diarrhea ☐dizziness ☐face flushed ☐fainting ☐fatigue ☐fever ☐head seems too heavy ☐headaches ☐insomnia ☐light bothers eyes ☐loss of balance ☐loss of smell ☐loss of taste ☐low resistance to colds ☐muscle jerking ☐numbness in fingers ☐numbness in toes ☐pins and needles in arms ☐pins and needles in legs ☐ringing in ears ☐shortness of breath ☐stiff neck ☐stomach upset

OTHER DOCTORS SEEN RECENTLY:_____ **FOR:**_____

Back on Track Chiropractic--2051 W. Warner Rd. #1 Chandler, AZ 85224 Phone: 480-963-0504 fax:480-963-2899

MEDICATIONS:_____
SURGERIES/HOSPITALIZATIONS:_____

MAJOR ILLNESSES YOU HAVE HAD:_____

MAJOR ILLNESS IN YOUR FAMILY:_____

WHAT ARE YOUR HEALTH CARE GOALS?

_____ Temporary Relief (Help the symptom but do not fix the cause of the problem)
_____ Maximum Correction (Correct the cause of the problem for maximum stability in the future)

WHAT ARE YOUR FAVORITE HOBBIES OR ACTIVITIES_____

_____

ARE YOUR CURRENT PROBLEMS AFFECTING THESE HOBBIES OR ACTIVITIES? ☐NO ☐YES

ON A SCALE OF 1-10 (1 being the least, 10 being the most)

_____ How committed are you at being at your maximum health potential?
_____ How important is it for your family to be at their optimum health potential?
_____ How committed are you to preventing arthritis and maximizing your health potential?

DISCLAIMER:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that all moneys will be credited to my account upon receipt. I, also authorize the release of any health information necessary to process this claim. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, the fees for professional services rendered me will be immediately due and payable. In the event of default I agree to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection. I authorize the use of this signature on all insurance submissions.

Patient's Signature: _____ **Date:**_____

Guardian Signature: _____ **Date:**_____

Back on Track Chiropractic
2051 W. Warner Rd. Suite 1
Chandler, AZ 85224

Date: _____

Authorization for Release of Information to Family and/or Friends

Name of Patient_____ Date of Birth_____

Back on Track Chiropractic is authorized to release health information pertaining to the above named patient to the entities below.

Entity to Receive Information- Initial each that is subject to this authorization:

_____Leave information on voice mail
_____Give information to spouse
_____Give information to the following persons:

Description of Information to be Released:

_____Financial Information
_____Results for, tests and/or x-rays
_____Family Billing Information
_____Medical information as follows:
_____Other information as described:

Rights of the Patient:
I understand that I have the right to revoke this authorization at any time by sending written notification. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that the information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State Law. Any information received by this office for our own use will continue to be protected by the Federal and State Privacy Rule.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

_____ _____
Signature of Patient/Personal Representative Expiration date(6 mos. if not specified)

_____
Description of Personal Representative's Authority (attach necessary documentation)

FAX RELEASE FORM TO: 480-963-2899

Back on Track Chiropractic
2051 W. Warner Rd. Suite 1
Chandler, AZ 85224-8700

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____

Back on Track Chiropractic
2051 W. Warner Rd. #1
Chandler, Arizona 85224

ASSIGNMENT OF BENEFITS
FOR PAYMENT OF CLAIMS FOR SERVICES RENDERED

This document constitutes written direction to each insurer with whom the undersigned is a covered insured pursuant to any provision which provides for payment for Chiropractic or other health related services rendered to or on behalf of such covered insured.

Each insured is hereby directed to make DIRECT PAYMENT to:

Back on Track Chiropractic
2051 W. Warner Rd. #1
Chandler, Arizona 85224

or as otherwise directed by Back on Track Chiropractic, of all or any portion of any benefits provided by the policy up to the total amount billed by Back on Track Chiropractic for services rendered to the undersigned. You are further directed to release to the above named provider any and all insurance information including extent of coverage as well as limitations of coverage.

This is made pursuant to a contractual assignment of benefits and cannot be revoked without the consent of both Back on Track Chiropractic and the undersigned.

IMPORTANT
If my current policy specifically prohibits direct payment to the doctor, then you are hereby also directed to make all checks payable to me and mailed as follows:

C/O Back on Track Chiropractic
2051 W. Warner Rd. #1
Chandler, Arizona 85224

I understand that I remain responsible for the total amounts due to the doctor for her services.

_____ _____
Date Signature of Insured

_____ _____
Date Authorized Signature for Back on Track Chiropractic.

Back on Track Chiropractic
2051 W. Warner Rd. ., SUITE 1
CHANDLER, AZ 85224
(480) 963-0504

INFORMED CONSENT & TERMS OF ACCEPTANCE FOR CHIROPRACTIC CARE

When a patient seeks chiropractic health care and when a chiropractor accepts a patient for such care, it is essential that both are speaking and working for the same goals. It is important that each patient understand both the objective and the method that will be used to attain it. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives. Chiropractic is a separate and distinct science, art, and practice. Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. One disturbance to the nervous system is called vertebral subluxations. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. The purpose of the nervous system is to control and coordinate all bodily function. This may result in pain and dysfunction or may be entirely asymptomatic.

The primary method for removing subluxations is through specific chiropractic adjustments (manual -by hand, hand held instrument, or drop table). There are times when the adjustment is supplemented with other methods such as traction, exercise, hot or cold packs, or other non-invasive modalities which your doctor considers necessary. These modalities are used in order to properly correct subluxations, or help the patient hold adjustments. In addition, nutritional supplements, orthotics or lifestyle counseling may be included if it is specifically for the purpose of helping the patient to be subluxations-free. With subluxations reduced, the body can begin the process of repair leading to better health. In some patients this happens quickly; in others, more slowly. In some patients the repair and maintenance is complete; in others, only partial.

We do not diagnose diseases nor claim to cure disease. However, if during the course of a chiropractic examination, we encounter non-chiropractic or unusual findings, we will recommend that you seek the services of a health care provider who specializes in that area.

- **There is a chance for soreness following your adjustments and rehabilitation. There is a possibility of symptoms worsening before noticeable improvement.**
- **There is also a chance (1/ 400,000** Dvorak J., Orelli F: Man Med 1985; 2:1-4**) of serious adverse complication (Vertebrobasilar Stroke) as a result of cervical spinal adjustments. Other possible complications include: sprain / strains, disc injury, fractures, rib fractures, dislocation**

PATIENT TREATMENT OPTIONS & ALTERNATIVES TO CHIROPRACTIC CARE:

- **Chiropractic Care:** Short Term Relief, Stabilization / Structural Correction, Wellness / Maintenance
- **Alternatives to chiropractic:** Do nothing, Physical Therapy, Medical Treatment (PCP), Specialist Referral by PCP, or other alternative healing arts

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name _____ Signature _____ Date _____

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

FEMALES: Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation, if necessary. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: _____/_____ _____

Signature Date